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### CST MEDICAL EVALUATION/CLIENT PROFILE FORM

Client Name \_\_\_\_\_ Contact Name/Phone \_\_\_\_\_  
 Disabling Condition \_\_\_\_\_ Onset \_\_\_\_\_ DOB \_\_\_\_\_  
 Assistive Tech/Medical Equip. currently being used: \_\_\_\_\_

Domicile      ☐ Home                      ☐ Hospital                      ☐ Nursing Home                      ☐ Rehab Facility

#### Abilities

- |   |   |                                     |                                    |
|---|---|-------------------------------------|------------------------------------|
| <input type="checkbox"/> controlled eyeblink      | hold credit card  | <input type="checkbox"/> right hand | <input type="checkbox"/> left hand |
| <input type="checkbox"/> controlled head movement | hold 1 inch cube  | <input type="checkbox"/> right hand | <input type="checkbox"/> left hand |
| <input type="checkbox"/> controlled arm movement  | hold a pencil   | <input type="checkbox"/> right hand | <input type="checkbox"/> left hand |
| <input type="checkbox"/> lift shoulders           | hold a grab bar   | <input type="checkbox"/> right hand | <input type="checkbox"/> left hand |
| <input type="checkbox"/> lift arm above shoulder  | press a button  | <input type="checkbox"/> right hand | <input type="checkbox"/> left hand |
| <input type="checkbox"/> lift arm above head      | hold a pea  | <input type="checkbox"/> right hand | <input type="checkbox"/> left hand |
| <input type="checkbox"/> bend at elbow            | grip a 3" ball  | <input type="checkbox"/> right hand | <input type="checkbox"/> left hand |
| <input type="checkbox"/> move fingers             | hold a suitcase handle                                    | <input type="checkbox"/> right hand | <input type="checkbox"/> left hand |
| <input type="checkbox"/> lift a paper folder      |   |                                     |                                    |
| <input type="checkbox"/> lift a mug of coffee     | Hand Dominance  | <input type="checkbox"/> right      | <input type="checkbox"/> left      |
| <input type="checkbox"/> lift a book              |   |                                     |                                    |
| <input type="checkbox"/> place palm of hand up    | What area has the most control for performing activities? |                                     |                                    |
| <input type="checkbox"/> place palm of hand down  | ex: all but right hand.                                   |                                     |                                    |
| <input type="checkbox"/> twist at waist           | _____   |                                     |                                    |
| <input type="checkbox"/> lean forward             | _____   |                                     |                                    |
| <input type="checkbox"/> bend at hips             | _____   |                                     |                                    |
| <input type="checkbox"/> bend at knees            | _____   |                                     |                                    |
| <input type="checkbox"/> bear weight on legs      | _____   |                                     |                                    |

#### Cognitive Ability

- ☐ OK  
☐ Memory Loss  
☐ Learning Disability  
☐ Developmental Disability

#### Communication

- ☐ Verbal  
☐ Sign  
☐ Eye Movement  
☐ Other:

(over)

**Hearing**      ☐ OK              ☐ Hearing Impaired              ☐ Deaf

**Vision**              ☐ OK              ☐ Visually Impaired              ☐ Visually Impaired/Corrected              ☐ Blind

**Mobility**              ☐ Walks independently              ☐ Manual Wheelchair-independent              ☐ Power wheelchair  
☐ Walks with assistance              ☐ Manual wheelchair- with assist              ☐ 3-wheel scooter

**Limitations**

- ☐ Strength:
- ☐ Speed:
- ☐ Endurance:
- ☐ Other:

**Medical Situation:**    ☐ Stable                      ☐ Transient                      ☐ Unstable/Serious

What are the client's most important needs? Please rank in order of importance

- 1.
- 2.
- 3.

**Action Plan:**

Resources Needed:

- ☐ BioMedical
- ☐ Computer
- ☐ Ergonomics
- ☐ Machining
- ☐ Medical/Rehab

Resources Available

- ☐ Equipment
- ☐ Labor
- ☐ Funds
- ☐ Other

Evaluator's Comments:

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Evaluator \_\_\_\_\_ Date \_\_\_\_\_